network
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Network Prison Special Edition

The prison Integrated Drug Treatment System (IDTS)

Providing good quality, effective drug treatment in prisons is vital for a number of reasons, including:

- People in prison are more likely than the general population to be socially excluded, to have substance misuse problems and to have mental health problems.
- Women prisoners have higher rates of self-harm and overdose than male prisoners.
- Injecting drug users are eight-times more likely to die in the two weeks following release from prison than at any other time in their lives: 97% of these deaths involve opiate drugs.
- Half of prison suicides occur in the first 28 days of custody, and drug-dependent individuals have double the risk of suicide in the first week of custody as compared to the general prison population.
- 60% of men and 37% of women in prison have a history of serious drink problems; half of men and women have current or past drug dependence

Therefore, getting drug treatment in prisons right can address a range of health and social exclusion issues. Particularly, substitution treatment in prison can reduce rates of re-offending and the rate of mortality among released prisoners.

The prison Integrated Drug Treatment System

Although drug treatment has been provided in prisons for many years now, it has not always been done well. The prison Integrated Drug Treatment System (IDTS) was introduced in 2006 to provide evidence-based drug treatment to people in prison, and has since expanded to 91 of a total of 133 adult prisons in England. IDTS offers clinical and psychosocial support including substitute prescribing and support for detoxification. Some prisons offer brief interventions for alcohol.

IDTS presents a challenge to prisons in terms of multi-agency working, organisational changes and the introduction of new policies and procedures. One of the key challenges is to balance the culture of drug treatment, which has its roots in a harm reduction philosophy, and the prison culture which, by necessity, has security as its central guiding force. The success of IDTS rests in effective communication between all professionals involved in the prison system.

Service user involvement and advocacy for service users is as important within the prison system, as it is within the community, and systems should enable access to both for prisoners.

Two-thirds of those coming into prison will lose their jobs. Some 30% of those leaving prison will be homeless. Effective care pathways are essential to resettlement and continuity of care across a number of domains including health, housing, and employment. The families and carers of prisoners can play a crucial role in their care and should be informed about and involved in these care pathways wherever possible.

Whilst it has generated debate and disagreements regarding clinical practice at times, IDTS has been welcomed by practitioners and prisoners as a positive way of improving people's health and well being, and breaking down barriers between different professions and between staff and patients.

In this issue

We hope you enjoy this edition.

Editor

Editorial

The National Treatment Agency for Substance Misuse (NTA) is pleased to support this special edition of SMMGP's *Network* newsletter, focusing on drug treatment in prisons.

This comes in a year that has seen significant developments in the range and extent of drug treatment in prisons, including the following:

- Implementation of the Integrated Drug Treatment System (IDTS) is underway in 91 prisons in England.
- Each NTA regional team has at least one IDTS development manager in post to support implementation and delivery
- Following a review of the funding of prison drug treatment in 2007, Department of Health and Ministry of Justice ministers announced the establishment of the Prison Drug Treatment Strategy Review Group to take forward its recommendations
- The new drug strategy contains clear commitment to further roll-out of IDTS and the introduction of minimum clinical standards in all prisons by 2011

The provision of effective drug treatment in prisons continues to be a major priority for the NTA and our partners across government. NTA regional teams are leading the roll-out of the IDTS implementation. The Government has committed to increase IDTS funding, rising from the £12.7m for 2007/8 to £24m in 2008/9, £39m in 2009/10 and £43m the year after. Finally, the National Drug Treatment Monitoring System (NDTMS) will be expanded to collect information on prisoners receiving drug treatment by 2009/10.

This work needs to be complemented by effective partnerships with doctors and other professionals working in prison drug treatment to be successful. This is why we welcome the publication of this newsletter. Working together to improve drug treatment received by patients in custody, we ensure effective continuity of treatment and care from the community, into prison, and back out again.

The NTA is grateful to SMMGP and the authors for all the hard work they have put into developing this newsletter. We realise that publications like this feature a range of expertise and opinion, and although we may not agree with everything said, we recognise that this is an excellent forum for debate on how to provide high quality drug treatment for people in prison. We hope you enjoy this special addition of *Network*, and look forward to future work with SMMGP to improve services for people in drug treatment, both in prison and in the community.

Annette Dale-Perera,

Director of Quality

NHS

National treatment Agency for Substance Misuse

We are excited to bring you this Prison Special Edition of Network, commissioned by the National Treatment Agency. The introduction of the Integrated Drug Treatment System (IDTS) began the long-needed process of providing evidence-based drug treatment in prisons. Primary care is at the heart of the development of IDTS. PCTs now have responsibility for commissioning primary healthcare within prisons at a level equitable with community services, and the majority of prison healthcare treatment is provided by GPs. The issues of drug use, offending, social exclusion and poor health are intertwined and self- compounding, and primary healthcare in prison can offer an invaluable opportunity to treat not simply drug use, but also a range of other health problems.

Well over half of the current national prison population have a history of drug use and such a large population moving frequently between the prison and community settings is a significant challenge to the effective provision of a drug treatment system that is integrated between the prison and the wider community. A common complaint from community services is that patients are often released unplanned from prison and there is, therefore a view that some prison drug treatment services are disorganised and haphazard. In response prison drug treatment services often feel that by the nature of the rapid turnover in remand prisons that they initiate far more treatment interventions than an equivalent community based service. We feel a need for greater awareness of the respective pressures in both community and prison drug services and feel that this view is reflected in the pages of this Special Edition. We have captured a full range of views of stakeholders including: service user advocates and service users; those involved in the development of policy; doctors who are delivering clinical IDTS services; prison pharmacists; the carers and relatives of drug users who are in prison; and those delivering IDTS psychosocial interventions within prison. A common theme throughout the articles is the general enthusiasm for the benefits IDTS brings to service users, their loved ones and carers, and professionals both in the prison and in the community.

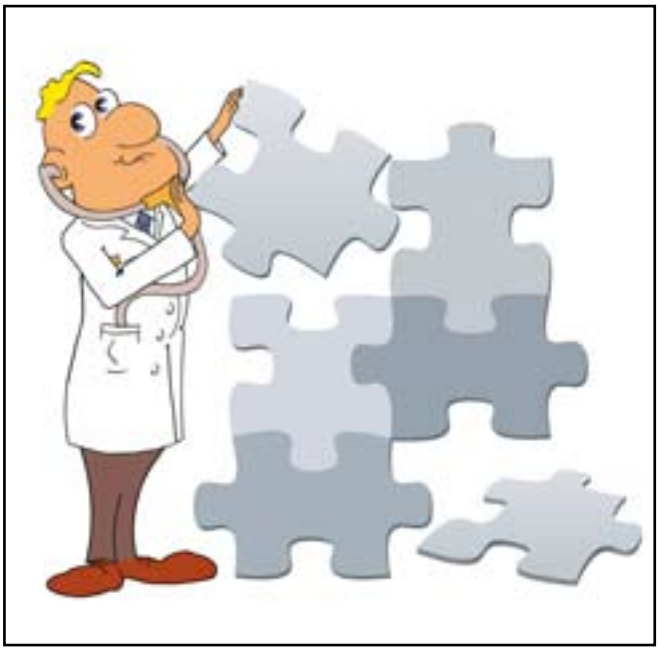
We hope you enjoy this issue!

Kate Halliday

Editor

Dave Marteau **outlines the events that led up to the development of IDTS, and the risks and challenges involved in its successful implementation. Ed.**

The introduction of the prison Integrated Drug Treatment System in England



The prison Integrated Drug Treatment System (IDTS), was launched in July 2006 by the National Treatment Agency (NTA) in 49 of the 131 prisons in England. IDTS features the provision of opioid substitution treatment, and the uniting of two separate treatment services in prisons: psychosocial drug treatment, known by the acronym CARATs (Counselling, Assessment, Referral, Advice, and Throughcare service) and clinical substance misuse management previously described as 'detoxification' services. Further investment followed in 2007 and 2008, and there are now 91 prisons funded to provide IDTS interventions.

The history of IDTS

2004 review of drug treatment in prisons

In 2004, representatives from the Prison Service, Department of Health (England) and the National Addiction Centre began a comprehensive review of clinical substance misuse management in adult prisons. At that time, in common with almost all prison systems around the world, detoxification was the standard clinical response to cases of opioid dependence in English prisons. This approach was often in contrast to practice in community drug treatment services where the majority of clients were treated using opiate substitutes (methadone and buprenorphine), and only a small percentage were detoxified (around 2% according to NDTMS figures).

Factors that were taken into consideration as part of this evaluation of the detoxification policy were:

- the vulnerability of drug-using prisoners to suicide and self-harm in prison, and to death upon release from custody due to accidental opiate overdose;
- prison regime management problems related to illicit drug use in prisons;
- the impetus to provide clinical services that corresponded to national and international good practice;
- the need to provide clinical interventions that were harmonious with practice in the community and other criminal justice settings; and
- the need to integrate further healthcare and CARAT services in prisons, to create multi-disciplinary drug teams.

Regarding the vulnerability of drug users to suicide in prison and to death on release, the review panel took account of an enquiry into suicides in prisons in England and Wales[1]. This inquiry found that half of the 172 suicides reviewed occurred in the first 28 days of custody, and that drug-dependent individuals entering prison had double the risk of suicide in the first week of custody when compared with the general prison population.

At the time of the review, there was limited experience of substitution treatments in prisons across the country, but methadone detoxification and maintenance programmes had become widely available in women's prisons. A sense of greater stability with a consequent reduction in self-harm was reported by many prisons that had introduced methadone programmes. The introduction of these programmes also coincided with a fall in self-inflicted deaths in women's prisons, from a total of 36 in the preceding three full years (2002-2004), to 15 in the three-year period 2005-2007 [2].

The very high number of fatal opioid overdoses amongst drug users leaving prison was also a key issue addressed by the review panel. Farrell and Marsden's study of more than 48,000 prison releases, [3] found that injecting drug users were eight-times more likely to die in the two weeks that followed release from prison than at any other time in their lives: 97% of these deaths involved opiate drugs. Loss of tolerance to the affects of opioids during imprisonment appeared to be the most likely explanation for these tragedies. Extrapolation of the Farrell and Marsden data suggested that more than175 ex-prisoners were dying each year in England during the first two weeks of liberty.

The panel also considered the results from a randomised control trial of methadone maintenance in prisons in New South Wales[4].

1 Shaw J, Appleby L and Baker D (2003) Safer Prisons: A National Study of Prison Suicides 1999–2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness London: Department of Health.

2 Inquest (2008) Deaths in women's prisons in England. http://www.inquest.gn.apc.org/data_deaths_of_woman_in_prison.html

Accessed 05.08.2008.

3 Farrell M and Marsden J (2005), Drug-related mortality among newly released offenders 1998 to 2000 Home Office Online Report 40/05.

4 Dolan K, Shearer J, MacDonald M, Mattick R, Hall W, Wodak A (2003). A randomised controlled trial of methadone maintenance versus wait list control in an Australian prison system. Drug and Alcohol Dependence; 72:59-65.

...continued on page 15

Nat Wright **offers advice on how to overcome potential barriers to setting up a clinical drug substitution service in a prison setting. He emphasises the importance of training, joint working, strong policies and procedures, and the careful management of resources in order to deliver a good clinical service. Ed.**

The clinical and organisational aspects of a large-scale prison substitution programme

The introduction of a large-scale prison substitution programme is unlikely to be straightforward. When compared to community services, there are significant barriers to running opiate maintenance programmes in the prison setting. I shall consider each of the barriers in turn.

Barrier 1: attitudes to prison and drug treatment

One of the most significant challenges is that different individuals will have differing views on the purpose of prison and, therefore, the legitimacy of treatment. At one extreme, people see prison as a place for punishment, an establishment where criminals are sent to receive their just desserts. At the other extreme, prison is viewed as a place of rehabilitation where drug users are in an ideal environment to withdraw and remain abstinent from illicit and prescribed drugs. For those over-wedded to the notion of punishment, the provision of opiate maintenance in prisons is tantamount to "going soft" on prisoners and wasting taxpayers' money on luxuries. For those who over-emphasise the power of prisons to be able to help drug users achieve lasting abstinence from all drugs, including substitute medication, the provision of opiate maintenance is seen as a healthcare induced block to users being able to achieve such a goal.

Meeting prisoners' health needs and reducing harm

The premise of rapid access for a large number of patients in prison-based opiate maintenance programmes has its treatment paradigm rooted in harm reduction philosophy. Harm reduction, whilst striving for abstinence from illicit drugs, pragmatically accepts that many users are unable to achieve such a goal at a given moment in time. It acknowledges that abstinence is not a realistic short-term goal for a number of drug users; this may particularly be the case for prisoners who lack the social support, employment, leisure activities, and self-efficacy of their peers. Such a treatment paradigm will acknowledge prison settings as ideal for some to achieve lasting abstinence. Abstinence may be achieved in prison for some because it is at this point that they hit "rock bottom" and find space to reflect upon the consequences of their behaviour. For others the reduced supply of drugs in prison as compared to the community makes abstinence from drugs possible. However, many of these individuals do not feel able to maintain a state of abstinence upon release and present to clinicians requesting opiate maintenance prior to liberation. Therefore the treatment philosophy behind the provision of large-scale opiate maintenance programmes in prison needs to be one of seeking to address health need.

> ***"Senior clinicians and managers, mindful of the wealth of international evidence supporting opiate maintenance in reducing criminal activity, drug related death and improving health, have a clear mandate to introduce programmes that address health needs, and not to engage in the ethical "rights and wrongs" of whether prisoners "deserve" such treatment."***

Senior clinicians and managers, mindful of the wealth of international evidence supporting opiate maintenance in reducing criminal activity, drug related death and improving health, have a clear mandate to introduce programmes that address health needs, and not to engage in the ethical "rights and wrongs" of whether prisoners "deserve" such treatment. So in addition to treatment philosophies that do not acknowledge the health gain achieved from a harm reduction approach, what are the other barriers that need to be overcome to introduce the IDTS programme?

Barrier 2: impact of running drug treatment programmes on the wider prison

One potential barrier is that the provision of opiate maintenance to large numbers of drug users invariably has an impact upon the wider running of the prison. Therefore it is imperative that clinical leads and heads of healthcare have regular meetings with the relevant security governors to ensure that the impact of dispensing opiate maintenance to large numbers of prisoners does not threaten the smooth running of the prison. Invariably there are trade-offs; for example a common sight now in IDTS prisons is of queues of prisoners waiting to receive methadone from an electronic dispensing machine. Some argue that such a system compromises patient confidentiality as those who are standing in the methadone queue are visible to other prisoners and staff. From my experience I have found this to be an occasional problem for users from black and minority ethnic populations who fear stigmatising attitudes from their communities if it becomes common knowledge that they have not achieved abstinence from all opiate based drugs (both illicit and prescribed). I am mindful of the sign that is increasingly seen in high street banks: "If you would like more privacy then please let a member of staff know". Maybe the high street banks have something to teach us? However, if everyone in the prison wanted to be taken individually to a discrete treatment centre to receive methadone on a daily basis then such a practice would inevitably mean that the increased time in accompanying prisoners from their cells to the treatment centre would lead to a reduction in the numbers able to receive such treatment. Therefore, reduced privacy may sometimes be the necessary price to pay for wider access to opiate maintenance.

The importance of competent prescribing

Training of staff is a critical component to the delivery of opiate maintenance treatment in particular so that common clinical risk scenarios can be avoided. A common clinical mistake, for example, is providing substitute medication to the patient on the first night of reception based upon their declared community dose, without confirmation of the dose with the community prescriber. Clearly this presents a risk of overdose if the user exaggerates their community dose. To avoid this situation, if the patient arrives in healthcare after 6pm their dose should be checked at earliest opportunity the next day. The dose needs to be confirmed as supervised within last 48 hours for same amount to be prescribed - otherwise the patient should start on lower dose (a maximum of 30ml) until the dose can be confirmed the following day.

Barrier 3: the impact of moving prisoners on in their treatment

Another barrier to the sustainability of opiate maintenance programmes is the difficulty that some remand prisons have in moving users on to another prison. This difficulty can be overcome by both establishments involving all the relevant parties in devising, agreeing and implementing a protocol regarding the transfer of prisoners on opiate maintenance. Problems arise when a patient may not want to be transferred. In such a scenario they may, for example, fabricate an overdose to try to either delay or stop their transfer. However, the current state of prison overcrowding is unable to make provision for all prisoners to choose which establishment they wish to stay in. Other problems arise when the timing of opiate dispensing is not the same between the two establishments. Therefore a prisoner risks being given maintenance medication earlier on the day following transfer. In such a situation the risk of overdose can be reduced by splitting the dose for two-to-three days.

> ***"A common clinical mistake…. is providing substitute medication to the patient on the first night of reception based upon their declared community dose, without confirmation of the dose with the community prescriber"***

Barrier 4: resource restrictions

Prior to the introduction of IDTS funding one of the common barriers to large-scale provision was the limited resource that was unable to meet the health need. Healthcare departments would prioritise opiate maintenance for those with a release date in the near future, or for those on short sentences. At the time of writing, this practice is still commonplace in many prisons where running a waiting list is not a feasible option. Where resource or organisational constraints prevent the provision of opiate maintenance that is not time-limited then I would suggest that the following should be core to the opiate maintenance programme:

- First, those on remand should not undergo detoxification from opiates unless they explicitly request this, as many remand prisoners are released, unplanned, into the community from court and are therefore at high risk of heroin overdose.
- Second, individuals who are received into prison taking either illicit heroin or prescribed opiates should not be detoxified in the first seven days whilst they adjust to time in prison. This period is a high-risk time for self-harm and self-inflicted death and stability is therefore required.

Where it is not possible to provide those serving long sentences (several years) with opiate maintenance for the duration of their sentence, easy access to re-induction onto opiates nearer a confirmed release date should be ensured for patients.

It is to be hoped that as resource is increased across the prison estate and matched with commitment at both policy and service-provider levels, so time-limited opiate maintenance will gradually become a dinosaur which fades to the back of our treatment memories as a significant step from the journey of *no-treatment* to *treatment for all according to individual need*.

Nat Wright, Clinical Director for Substance Misuse, HMP Leeds.

Jack Leach **argues for optimising drug treatment in prison and for improved care pathways between prisons and the community. Ed.**

The treatment of substance users in prison: easy to reach but easier to ignore?

In this article I consider three aspects of the treatment of drug users in prison that I dearly hope IDTS will address: improving the initial treatment of drug users on reception into prison; optimising treatment programmes whilst people are in prison; and improving continuation of care after release.

Improving initial treatment at reception

Many people received into prison have drug and alcohol problems [1]. A UK study found that: 60% of men and 37% of women had a history of serious drink problems; half of men and women had current or past drug dependence; around a fifth of men and women continued to use illicit drugs whilst in prison; and there are high levels of mental health problems amongst prison inmates, often associated with problem drug and alcohol use [2].

Receptions to prison are frequently at night and weekends when community substance misuse services, general practitioners and pharmacists are shut. So there is often little background information to support the hastily carried out reception assessment by staff who may have relatively little experience of working with people with substance misuse or mental health issues. It can appear that prison prescribing procedures are aimed at the lowest possible dose of methadone with the principal aim of not causing death from prescribed methadone. However, it is possible to distinguish between persons who experience major drug use and dependence, and those who do not, by taking a good drug history, and by conducting an examination for signs of withdrawal, signs of intoxication and the occurrence of injection sites - without an over-reliance on on-site urine testing.

Optimising drug treatment in prison

It is essential to get further information regarding a new prisoner from general practitioners, substance misuse services and pharmacies, to help guide treatment. This information can go above and beyond a list of prescribed medication but can also be used to guide the patient's overall care plan.

The 2007 Clinical Guidelines [1] suggest that people in prison will commonly achieve stability on a lower dose of methadone than those in the community (though the guidance makes the point that some will require equivalent doses). I have been unable to find any research that supports this. Certainly, people in prison seem to expect, and get, less methadone than is prescribed in the community, but this does not necessarily mean they need less, or that more would be more harmful than beneficial.

I believe the dangers of over-treatment with opiate replacement treatment are over-estimated. Three reasons are generally given for low dosing prescribing in prison:

- **The dangers of methadone poisoning**. A proper assessment including obtaining background information should ensure that methadone is prescribed to people who have established opiate dependence at appropriate dosing.
- **Concerns about prisoners bringing in and using illicit drugs that may interact and cause poisoning with methadone**. I believe this risk is less than in the community for three reasons: illicit drugs are less available; very few people seem to inject in prison; and the prisoners are rarely alone (there are nursing staff, prison guards and other prisoners around who can raise the alarm if a prisoner becomes unwell).
- **The dose of methadone remains low so prisoners can be transferred across the prison estate**. Prisoners may quite reasonably be transferred as part of preparation for release to a lower category prison with greater emphasis on rehabilitation. However, many prisons put a limit on the dose of methadone they will accept, and for many that has generally been low (30-40mg daily maximum) - and some prisons not currently funded for IDTS will offer no opiate replacement medication at all. Thus prisons are reluctant to increase the methadone dose above 30-40mg so that they can still transfer prisoners to other establishments.

In my experience the dangers of under-treatment are underestimated and include:

- inadequate dosing leading to opiate withdrawal and suffering
- withdrawal as a result of under-treatment can lead to illicit drug use in prison and its health and social consequences
- opiate withdrawal may aggravate mood and anxiety disorders and is associated with intentional self-harm and suicide [3].

The Home Office provides details of all deaths in prison. There is a very high overall death rate, particularly among female prisoners (see table 1), much higher than the general population. The major cause of death is from suicide and 'killing themselves' (see table 2). This could be because prisoners are a group who, regardless of where they are, have a high suicide rate, or because the setting of prison is a high-risk contributing factor - or a combination of both. Only one death during the four-year period was attributed

1 Department of Health (England) and the devolved administrations (2007) Drug misuse and dependence: UK guidelines on clinical management: London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

2 Shewan D, Davies J (editors) (2000). Drug use and prisons: an international perspective. Amsterdam: Harwood Academic Publishers.

3 Shaw J, Appleby L and Baker D (2003). Safer prisons; a national study of prison suicides 1999-2000 by the national confidential Inquiry into Suicides and Homicides by people with mental illness. London: Department of Health.

directly to drug use and I could find no inquest finding stating that methadone poisoning contributed to the death.

Table 1: Death rates in English prison 2002-2005 (Source: Home Office 2008)

	MEN	WOMEN	TOTAL
Actual deaths	684	59	743
Expected deaths	565.63	8.23	573.86
Difference	118.37	50.77	169.14
Difference (%)	20.93	616.89	29.47
Based on age specific death rate for men (40-45y) of 2 per 1000			
and age specific death rate of women (30-35y) of 0.47 per 1000			

Table 2: Cause of death in 2002 at Inquest

CAUSE OF DEATH	NUMBER IN 2002
SUICIDE/KILLED SELF	47
NATURAL CAUSES	44
LEFT BLANK	25
OPEN	19
NO INQUEST	8
ACCIDENTAL	8
MISADVENTURE	6
KILLED WHILST BALANCE OF MIND DISTURBED	5
DEPENDENT ABUSE OF DRUGS	1
TOTAL	163

Reducing death and relapse after release

Studies have found that after release from prison there is a high death rate from drugs [4, 5, 6] and from suicide [7, 8] and that there is a high risk of relapse back to problematic substance misuse and associated health and social problems [1].

It can be difficult to know when a prisoner is due for release. Prisoners, particularly those on remand, may be released unexpectedly from court. Such unexpected movement makes continuity of care difficult. However, there are systems that have been tried across the country that might help reduce these problems:

- prison healthcare departments have issued take-home medication or even community prescriptions to continue the prisoner's medication until they can be seen by their community or primary care services
- community prison liaison workers see prisoners before release and co-ordinate a post-release treatment plan
- gate pick-ups are arranged to take the person to whatever clinic or appointment they need to go to ensure continuity of their treatment or care
- quick access is provided to community one-to-one counselling or support groups for relapse prevention and supported activities
- immediate access is provided to released prisoners for a range of medication options including; continuation of opiate replacement treatment programmes from prison, naltrexone, and re-induction with buprenorphine (this is yet to be fully evaluated, but in practice it seems helpful for some people in difficult social circumstances on release, for example homeless people with a long history of drug use and a high risk of relapse).

Conclusions

Many prisoners have substance misuse problems, poor mental health and poor physical health, or a combination of all three. They are entitled to good quality care and treatment. The high death rate in prison, mainly from deliberate self-harm rather than overdose, seems to indicate that the risk to health and the risk of death in custody has been more from under-treatment of substance misuse and mental illness in prison, than from over-treatment. There is a high death-rate following release from drug overdose and suicide and improving the continuity of care following release should reduce the risk of this happening. A big challenge for IDTS is that its successful implementation will involve more than an increase in funding, and will necessitate a change in culture, systems, and attitudes to prisoners with substance misuse and mental health problems.

Jack Leach, Clinical Director, Cheshire Substance Misuse Services, Cheshire and Wirral Partnership NHS Foundation Trust

4 Farrell M, Marsden J (2008) Acute risk of drug-related death among newly released prisoners in England and Wales. Addiction. 2008 Feb;103(2):251-5.

5 Bird S, Hutchinson S (2003) Male drugs-related deaths in the fortnight after release from prison; Scotland 1996-99. Addiction;98:185-190.

6 Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD (2007) Release from prison--a high risk of death for former inmates. N Engl J Med. 2007 Jan 11;356(2):157-65.

7 Kariminia A, Law MG, Butler TG, Levy MH, Corben SP, Kaldor JM, Grant L (2007) Suicide risk among recently released prisoners in New South Wales, Australia. Med J Aust. 2007 Oct 1;187(7):387-90.

8 Pratt D, Piper M, Appleby L, Webb R, Shaw J (2006) Suicide in recently released prisoners: a population-based cohort study. Lancet. 2006 Jul 8;368(9530):119-23.

Can advocacy work in prisons? *Si Parry* discusses the important role advocates can have in prisoners' lives and yet the difficulties prisoners can face when trying to access advocacy services. He comes up with a useful suggestion for how to make contact with advocates easier for people in prison. Ed.

Advocacy in prisons

morph was started in 2004 by two of us who, after 10 years of heroin-addiction, decided we needed help stopping; and we soon discovered the sorry state of the local services. It took 6 months to get our Subutex! Coming from a punk rock / DIY background we were compelled to do something about it for future addicts – not just moan.

We did a number of things including: setting up a weekly meeting; got places on all the local committees devoted to drugs; began facilitating service user forums; started a newsletter - *Morphin'* - and set up an e-warning system to disseminate *bad drug warnings*. We discovered advocacy, and thanks to funding from the NTA, attended The Alliance's Advocacy Training. We then set up our 'mPower' Advocacy Service.

> ***"the first rule of advocacy is to empower the client to do things for themselves where possible, helping them along the path to independence – but it's a delicate balance"***

Drug advocates are like solicitors for someone in the drug treatment system. They know the lingo, the systems, who does what, how long things take; and from *a non-judgmental position* represent the wishes of the client. They help negotiate and they provide information, options and possible outcomes. *Unlike* solicitors, the first rule of advocacy is to empower the client to do things for themselves where possible, helping them along the path to independence – but it's a delicate balance. It is crucial that the advocate is independent.

Advocacy is most commonly provided to those with mental ill-health or learning disabilities – although *drug advocates* are increasingly available. Advocating for anyone presents challenges; these are seriously compounded if your client gets sent to prison – or they're already in there! We have to bear in mind that when you can get locked up for possessing a drug you're addicted to, prison becomes an occupational hazard for drug users. Some see it as detox! Don't forget, incarceration could happen *after* someone has asked for help, been put on a waiting list and told to "carry on doing what you're doing. We'll be in touch".

Prison presents new problems for advocacy; overcrowding means just knowing where your client *is* can be problematic – let alone communicating with them. The number of inmates has gone from 61,500 to a maxed-out 83,300 under New Labour! Here is an example of the sorts of problems unique to prison-based advocacy:

Following a talk I did at HMP Winchester, a guy asked if I could advocate for him. With literally seconds until I had to leave, I got his name and number and began communicating by letter. His partner was also in jail, so we agreed to use one of his social visits to meet up. Having arrived on time (and provided a humorous diversion for the officers whilst everything metallic was removed from my person; ear-rings, bracelets, rings, necklace, watch, ID, etc) I was told "my prisoner" wasn't there! Which threw me right out! I even had a visitor number! I left… confused… full of self-doubt; what was I doing? Who was I kidding? Was I *really* helping anyone? What a wind-up for my client. Had I somehow become a 'bleeding-heart liberal' trying to 'help the poor' but doing more harm than good? Luckily, a letter arrived from him a few days later, explaining he'd been "ghosted" to another nick at short notice, apologising for any inconvenience.

So what to do? Rather than just whinge, here is a suggestion that may improve things: *establish advocacy visits*. Using social visits for advocacy is unfair and undermines confidentiality. Pens and paper (including consent forms), aren't permitted, and social visits are *time limited*. Getting consent forms signed for advocacy is *crucial:* no one should deal with us without them.

We feel advocacy services should be promoted and available for all inmates but accessing services can be very difficult. Using the post is a big problem. All letters can be read by prison officials (except solicitor's letters) – hardly confidential! The numbers of stamps, envelopes and paper available are limited for those in prison. Phone calls during 'association' are a possibility – but who would you rather ring? Your partner or your advocate? And association is often during the evening when many advocates will not be available to be contacted.

We recently wrote to a prison governor about booking legal visits for advocacy – although having since discussed it with the drug officers, we think we've found a better solution: working with the CARAT teams to provide a room (it may also avoid the apparent *two week* wait for legal visits!). This would be great: we could chat candidly, get consent forms signed, and check that inmates are aware of Drug Rehabilitation Requirements Orders (DRR) and how to get assessed for one. We can also help prepare things for their release: relapse-prevention groups; on-going treatment; peer-support; volunteering; and any other activity that may help.

This whole subject of advocates' access to their clients in prison needs to be addressed nationally; an inmate accessing a visit from an advocate should become part of prison culture – like legal visits are now. We're raising it wherever we think it'll help (for example the Department of Health [Offender Health], Integrated Drug Treatment System, the NTA) and will continue to do so. Anyone reading this who'd like to help, or has any suggestions or questions, please contact us.

Si Parry & Sue Tutton – Project Co-ordinators

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How does prison pharmacy deal with the introduction of IDTS? *Cathy Cooke* takes us through the experience of HMP Bristol pharmacy and encourages other prison pharmacists to get involved with the Prison Pharmacy Forum. Ed.

Integrated Drug Treatment System at HMP Bristol: a pharmacy perspective

Preparing for IDTS

Prior to the introduction of the IDTS, HMP Bristol was already delivering a comprehensive range of clinical treatments for substance misuse, so it wasn't that much of a culture shock to bring our practice in line with the IDTS requirements. An IDTS steering group, of which I am a member, has been meeting for over two years, so we had plenty of time to work out what we needed to do to meet the criteria - but that didn't necessarily mean that we were totally ready for the launch! Part of the implementation involved the conversion of one wing to a dedicated IDTS wing; this has progressed, but not without some problems!

Using patient group directives

Before the introduction of early-evening medical cover to assess new receptions with substance misuse problems, we used a range of patient group directives (PGDs) to allow reception nurses to respond to the symptoms being experienced by prisoners in opiate, benzodiazepine or alcohol withdrawal. Loperamide, analgesics, mebeverine, buccal, prochlorperazine and zopiclone were used to relieve symptoms of opiate withdrawal. For about a year before IDTS implementation, we had been using carbamazepine (with a PGD) as a treatment of withdrawal from alcohol - and for around 6 months, for benzodiazepines - for new receptions. Carbamazepine had been introduced to replace diazepam and chlordiazepoxide because of the significant problems experienced with diversion with the latter drugs. With IDTS, we had to revert to using benzodiazepines again because of the more substantial evidence-base, even though our experience of using carbamazepine was positive. We decided to use diazepam syrup to try to minimise the risk of diversion and we have introduced two methods of monitoring its use. On the dedicated substance misuse wing, nursing staff administer from stock and record all supplies and receipts in a controlled drugs (CDs) register. On the other wings where usage is lighter, the pharmacy department supplies bottles, as named-patient medication, and monitors that demand is in line with expected usage. Now that prisoners are initiated on substitution treatment soon after reception, we find that the PGDs set up to deal with symptoms of withdrawal are no longer needed.

Increase in prisoners prescribed methadone

The vast majority of patients who are prescribed an opiate substitute receive methadone, with a small number being maintained on buprenorphine if they were already on this treatment prior to incarceration, or for treatment as a rapid detox. This makes supervised consumption more easy to manage, taking into account the increased supervision requirements and the greater diversion potential of buprenorphine as compared with methadone. The effect of IDTS has meant that the numbers of prisoners taking methadone at any one time has increased almost three-fold, and the average maintenance dose used has increased. This has had a significant effect on the workload of the pharmacy department, exacerbated by an unfortunate delay in the computerised methadone dispensing system becoming operational. We currently spend over four-hours daily of pharmacy time processing and documenting around 100 individual doses of methadone, rising to over 300 on Fridays to cover the weekend!

> *"The effect of IDTS has meant that the numbers of prisoners taking methadone at any one time has increased almost three-fold, and the average maintenance dose used has increased."*

Changes to controlled drug regulations

The changes to the regulations governing controlled drugs and the publication of guidance around their use coincided with the IDTS introduction, so we have drawn up standard operating procedures for activities involving CDs. Changing *current practice* to *best practice* is proving difficult in some cases; for example, staffing levels only allow one member of staff to be available to administer medication on the majority of the wings, so there is no witness. The pharmacy department is supplying named doses on a daily basis but, even where the dose is being measured by the computerised dispensing equipment, Department of Health guidance suggests that an appropriately trained staff member witnesses the administration by a nurse. Another issue is that the iris recognition system is located on the substance misuse wing but there are, and will continue to be, a sizeable number of prisoners receiving IDTS treatment who are located on other wings. Some will be located on the vulnerable prisoner wing or in the healthcare in-patient unit, but even including these exceptions, the capacity of the specialist wing has been exceeded and stabilised patients now need to be located elsewhere. These prisoners, and the nursing staff looking after them, miss out on the risk minimisation advantages of the high-tech equipment. In addition to this, the limited willingness and capacity to take prisoners on opiate substitutes of those Category C prisons that have actually gone live with IDTS, has a knock-back effect on the local prisons.

Links with community services

We are lucky in Bristol to have a good provision of substance misuse services in the community so our teams were already working with these agencies to optimise continuity of care for prisoners on release prior to the introduction of IDTS. HMP Bristol is a pilot site for the use of FP10 and FP10MDA prescriptions, which will be used instead of issuing TTOs (To Take Out prescriptions) for methadone and buprenorphine on release, to minimise the risk of diversion or overdose. The pharmacy team isn't involved in arranging on-going prescribing of substitute medication for prisoners. However, using our pharmacy computer records, we frequently respond to queries regarding confirmation of medication and doses, when remand prisoners are released from court, an area where the management of care continues to be problematic (this is less frequently the case for IDTS patients where arrangements have already been made).

Prison Pharmacy Forum

The Prison Pharmacy Forum is an e-mail networking group for pharmacists, technicians, nurses and anyone else wanting help, information and advice on medicines management and related issues. I am also chairperson of the Secure Environment Pharmacists' Group (formerly the Prison Pharmacists' Forum), which meets quarterly, and has representation from the Department of Health and the Royal Pharmaceutical Society of Great Britain. This group discusses anything from training and education, to policies, guidance and audit. If you would like any information about either of these groups, please email me at cathy.cooke@hmps.gsi.gov.uk

Cathy Cooke, Bristol PCT Senior Specialist Pharmacist Prison Healthcare, Head of Pharmacy, HMP Bristol.

Jan Palmer **outlines the specific issues faced by female prisoners for whom issues of self-harm, suicide and overdose are greater than for male prisoners. She identifies the need for strong multi agency working, including strong links between prisons and the community, in order to meet the needs not only of women who are offending, but also to meet the needs of their children. Ed.**

Clinical substance misuse and related issues in women's prisons

Introduction

There are 141 prisons in England and Wales, of which 14 are for women. The total prison population on 4th July 2008 was 83,330, of whom 4,524 were women[1].

Whilst the female prison population rose by 191% from 1580 in 1993, to 4589 in 2004[2] this growth has now stabilised; however the male population is continuing to rise. One result of the continuous rise in the male prison population has been the re-classification from female to male of several of the women's prisons; thus many women are not held near to their home which in turn causes issues with family contact and visits. This is of particular importance when 66% of women in prison are mothers with dependent children under the age of 18 years[3].

Substance misuse

Of all women being received into female prisons, 60-70% require a clinical substance misuse intervention upon admission. An unpublished study undertaken at Holloway prison in 2001 suggested that a further 20% of women were also using drugs at the time of arrest. Other studies indicate that problematic drug use is higher amongst women than men, [4] with European prisons also reporting that 75% of women are using drugs problematically at the point of reception into prison [5].

Many women are injecting poly-drug users who report use of between six and nine substances[6] (although regional variations with regard to what they are actually using do apply); this picture is supported by other studies which also report a higher rate of injecting drug use for women [4].

Self-harm

All acts of self-harm bring with them a risk of self-inflicted death. Rates of self-harm in prison are higher than in the community[7]. In 2003 there were 16,214 incidents of self-harm by women in prison, which is almost half of the total for the whole prison population, even though women only account for 6% of this population [8]. Women are 14 times more likely to self-harm than men[9]. The reasons for the higher rates of self-harm amongst women may in part be attributed to the fact that a substantial proportion of women in prison have experienced abuse,[10] and there is a statistically significant association between abuse, self-harm and attempted suicide amongst female prisoners: 41% of those who self-harm and attempt suicide report that they had been abused [11].

The risk of self-harm is a particular issue for women's prisons and is increased during withdrawal. This risk is confirmed by a National Confidential Inquiry by the Department of Health in 2003, which reported that 51% of all self inflicted deaths in prisons occurred within the first 28 days of custody, a finding also supported by Crighton and Towel [12] (though this report was not gender specific). In 2002 the Safer Custody Group[13] further acknowledged the vulnerability of substance misusers during the first 28 days, identifying 62% of those who died during this period as being problematic drug users. With a high level of women misusing substances at the time of arrival in prison and, therefore, likely to experience some level of withdrawal, many women are in this high-risk category. The recognition of this risk has been in part responsible for the development of at least basic clinical substance misuse services in women's prisons ahead of the IDTS funding, as a number of inquests found that women had killed themselves in prison during the first four weeks of custody, whilst in withdrawal.

The introduction of methadone programmes prior to IDTS has coincided

1 HM Prison Service (2008). http://www.hmprison-service.gov.uk

2 Offender Management Caseload Statistics (2003).

3 Prison Reform Trust (2006). Bromley Briefings Prison Factfile, November 2006, p.16 .

4 European Monitoring Centre for Drugs and Drug Addiction.Annual Report (2004) The State of the Drugs Problem in the European Union and Norway. http://ar2004.emcdda.europa.eu/en/page096-en.html cited in Women in Prison: A Review of the Conditions in Member States of the council of Europe. The Quaker council for European Affairs (2007).

5 Fowler V. (2001) Drug Services for Youth and Women in Prison in Europe: The Impact of the Marseilles Recommendations. London. The European Network for drug and HIV/AIDS Services in prisons (ENDHASP) Cranstoun Drug Services.

6 Palmer J (2003) Clinical Management and Treatment of Substance Misuse for Women in Prison. Central and North West London NHS Mental Health Trust.

7 Snow L. (2005) Personal Correspondence.

8 Shaw J., Appleby L., Baker D. (2003) Safer Prisons: A National Study of Prison Suicides 1999 – 2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness. London. Department of Health.

9 Safer Custody Group (2003) Reported Self Harm in HM Prison Service. Unpublished report.

10 Hooper C. A. (2003) Abuse, Interventions and Women in Prison. Home Office. London.

11 Snow L. (2002) Attempted suicide and Self Injury in Prison: An Exploration of Risk Factors and Motivations. Unpublished PhD Thesis. University of Kent.

12 Crighton D., & Towle G. (1997) Self Inflicted Deaths in Prison in England and Wales: an analysis of the data for 1988-90 and 1994-5. In Towl G., (Ed) Suicide and Self Injury in Prisons, Issues in Criminological and Legal Psychology 28: 12 -20. Leicester: The British Psychological Society.

13 Safer Custody Internal Report (2002) HM Prison Service.

with a fall in self-inflicted deaths in women's prisons, from a total of 36 in the three full years that preceded the full introduction of methadone detoxification (2002-2004), to 15 in the three-year period when methadone programmes were universally available to women in prison (2005-2007)[14].

Post-release deaths

One study found that women are 69 times more likely to die in the week following release from prison than the general population, and that in the four weeks following release all deaths for women were drug related[15]. The fact that there is a high level of injecting reported by female substance misusers upon arrival in prison, [3] together with the fact that opiates were found to be involved in 97% of all deaths for both men and women in the first two weeks of release[11] leads to the assumption that a loss of opiate tolerance during time in prison, followed by a return to injecting opiates when released, puts women at a greatly increased risk of opiate overdose on liberation from custody.

Ensuring an opiate substitution regime is in place for all women who are released from custody is, therefore, a highly protective factor in reducing the risks of post-release overdose amongst women prisoners; this practice is supported by one research study[16]. Although women's prisons have offered methadone maintenance regimes for several years now, until IDTS funding is available to all women's prisons, there are capacity issues which limit the availability of this highly protective treatment.

Other health related and lifestyle issues

Female substance misusers present with a wide range of additional healthcare issues upon arrival in prison including abscesses, blood borne viruses as a result of injecting drug use, and sexually transmitted diseases as a result of unprotected sexual activity or prostitution. The general health of female prisoners is often poor as women neglect themselves in favour of their drug use, and they often have concurrent infections, malnutrition and infestations.

> *"66% of women in prison are mothers with dependent children under the age of 18 years"*

The demand on wider healthcare provision in local prisons is, therefore, very heavy; this includes the requests for dentistry as opiate users frequently have many dental problems which emerge as the analgesic effect of their previous drug use wear off. Many women suffer from amenorrhoea due to their opiate use, with menstruation recommencing during withdrawal. For the short-term prisoner this also increases the risk of pregnancy upon release from prison.

Pregnancy

It is not uncommon for drug using women to discover that they are pregnant when they arrive in prison. This can be a very distressing time for them as they are then often unsure about what they want to do about the pregnancy, particularly as they have to make decisions when separated from their partner and other friends and family. They need considerable support during this difficult time to enable them to make informed decisions. Their view of the pregnancy will also be influenced by their past child-care abilities, the length of the sentence they may be facing, presence or absence of partner and family support, the gestation and the circumstances which have resulted in the pregnancy.

Even if they know they are pregnant, women often do not know the gestation, and in keeping with drug users in the community, have often not accessed ante-natal services prior to their arrest, even if the pregnancy is well advanced [17]; this makes the management of pregnancies more complex and high risk and presents particular challenges to the prison healthcare team (that works in partnership with the local NHS obstetric and midwifery services, often with the involvement of specialist drug liaison midwives).

Routinely there are child protection concerns when a mother presents with a history of both substance misuse and offending, and prison is often the one opportunity that there is for all professionals to know where the patient is, to be able to undertake assessments and to communicate regularly with the woman herself. Unfortunately, even with very robust care planning and attempts to link these women into services upon their release, it can still prove problematic to retain this group in treatment when they return home, and there is a constant risk of loss of contact and therefore concerns about the risks to the child. This problem is exacerbated when the period in custody is very brief, or when there are several short periods of imprisonment during one pregnancy.

Conclusion

Whilst there is a need to provide effective substance misuse services for both men and women in prison, it is important that the range of treatment takes into account gender-specific needs. Women prisoners present with a particularly high level of demand on the wider healthcare services in prisons, due to the concurrent health related issues that accompany their severe poly-drug use.

Both the risk of self-harm in prison and the risk of post-release deaths are greater for women than they are for men, and substance misuse services in women's prisons need to take account of these particular factors in their treatment planning.

Continuity of care for women leaving prison presents particular challenges due to the fact that, with only 14 female prisons in England and Wales, a woman prisoner is likely to be held in a prison many miles from her home making pre-release visits and care planning with community services more problematic. Many women are also mothers, and treatment plans upon release need to take account of this to consider any identified child protection issues, and how parenthood may influence the choice of ongoing treatment options.

Jan Palmer, Clinical Substance Misuse Lead, Offender Health.

14 Inquest (2008) Deaths in women's prisons in England. http://www.inquest.gn.apc.org/data_deaths_of_woman_in_prison.html

15 Farrell M., Marsden J.(2005) Drug-related mortality among newly released offenders 1998 to 2000 - Home Office Online Report 40/05.

16 Dolan K E., et al. (2005) Four Year Follow-up of Imprisoned Male Heroin Users and Methadone Treatment: Mortality, Re-incarceration and Hepatitis C Infection. Addiction; 100; 820 – 828.

17 Day E., George S. (2005) Management of Drug Misuse in Pregnancy. Advances in Psychiatric Treatment. Vol 11; 253 –261.

...continued on back page

Leanne Coulson **discusses the experiences of family members and carers when their loved one goes into prison, and the important role they can play in their rehabilitation. She describes the range of emotions carers can experience throughout the process of incarceration, and calls for better communication between prisons and families/ carers at every stage of the sentencing process. Ed.**

Carers' experience of the criminal justice system

"The first time he went to prison it was like he had died, it was like a bereavement." This statement is from a mother whose young son had been given his first custodial sentence at a young offender institution. She is not alone in her distress. This article focuses on the experience of carers when a loved one enters the prison system and the affect that their journey can have on those closest to them.

It is safe to say that, from a carer's perspective, by the time their loved one does enter the prison system the family have lived with the consequences of the offender's behaviour for some considerable amount of time. Carers have described this stage of their journey as absolutely exhausting. Depression, anxiety, stress and hopelessness are feelings commonly described by family members.

In the years that I have supported families of substance misusers, I have regularly found myself standing in a variety of courts. There have been many times when I have advocated on a family's behalf and have felt the need to ask if I can speak to the magistrates: to let them know what it has really been like for the family. On a more personal note, on two occasions I can remember asking magistrates if they would give my brothers a custodial sentence, as I simply could no longer cope living with their heroin addiction. I'm pleased to say, my brothers understood my reasons behind this, and in fact my younger brother saw prison as the only way of - in his words - *"getting off this shite"*.

It does get a bit easier each time he goes away. At the point a drug user enters prison we will often hear carers saying they feel a sense of relief. This is often due to the months or years of stress a carer has gone through, whilst supporting and caring for their loved one. *"At least I know where he is, he's safe, he's getting three meals a day, and I know he will be getting treatment for his drug use"* stated a woman whose partner had received a custodial sentence for the first time. However, carers will often say they are worried about their loved one going on to use "harder drugs" whilst in custody: *"when my son went into prison, he had a problem with cannabis use. When he was released though, he'd picked up a heroin habit"*.

Carers do worry that their loved ones will be able to purchase illegal substances in prisons. When I asked about how easy they thought it would be for a prisoner to purchase drugs, carers stated *"it's probably very easy"*. When I asked carers whether there was anything prison staff could do, in order to inform families any better, they said *"just knowing he/she is OK, especially if they are detoxing"*. Carers also said that the first time they visit a prison, *"it's terrifying"*. They are unsure of the procedure, and find the whole experience frightening. Prisons are recognising that first-time visits can be a daunting experience and, as a result, procedures and support are being put in place in some prisons - but this does depend on the area that you live in.

> ***"I can remember asking magistrates if they would give my brothers a custodial sentence, as I simply could no longer cope living with their heroin addiction"***

Carers become increasingly anxious when their loved one's release date is imminent. They are often extremely hopeful that whilst their child/ partner/ sibling/ loved one is in prison, then they are "drug free" and getting the "help" they need; but once they are released, the stress begins again and, understandably, their ultimate fear is that they will return to substance misuse; and for the carers, that dreadful cycle will begin again. *"How can I plan when I don't even know the date he's being released?"* asked one mum. "*He's been told his release date is anywhere from the 4th to the 21st of this month - what if it's a Friday afternoon, and there's no treatment agencies open until the Monday - how will he get his medication?"*

It is fair to say that the criminal justice system, in terms of substance misuse, has come on leaps and bounds (since back in the day when I was a regular visitor to my brother), but I feel, in terms of family members, we still have some way to go. *Communication* between secure estate and families would be the ideal starting point. Keeping family members informed isn't much to ask, given the fact that most of us will be supporting the prisoner upon their release, and it is widely proven through research that a drug user returning to a supportive family has a much better chance of being successfully engaged and retained in treatment services.

Leanne Coulson Carer and Family Intervention Worker Newcastle PROPS (Positive Response To Overcoming Problems of Substance Misuse in Families).

Gail Styles **describes the role that brief interventions for alcohol in a prison setting can play in supporting prisoners to address problematic alcohol use. Ed.**

Brief interventions for alcohol in prisons

Background

Alcohol is a problem for a significant number of individuals entering prison. A study conducted by the Office for National Statistics reported that 63% of sentenced males, and 39% of sentenced females were classed as hazardous drinkers in the year before coming into prison[1]. The majority of these prisoners were assessed has having low-to-medium treatment needs and an estimated 8% of females and 7% of males were assessed as having high treatment needs. The Government's National Alcohol Harm Reduction Strategy 2004[2] estimated that alcohol-related crime costs society up to £7.3 billion per annum.

In line with Government policy, the Prison Service has developed an Alcohol Strategy [3] that complements the existing Drug Strategy, giving the Prison Service a consistent approach to tackling substance misuse as a whole. In addition, an Alcohol Intervention Guide [4] describes a treatment framework, including a range of interventions that can be provided.

CARATs, a team of qualified, experienced substance misuse workers, provide low threshold interventions for prisoners presenting with drug/ drug and alcohol problems. This service carries out individual assessment, care planning, key working, groupwork and release planning and is also the main provider of brief interventions for alcohol in prisons. CARATs is accessible to all prisoners at any point throughout their time in custody and self-referrals are accepted.

> ***"Within a prison setting, screening for and provision of brief interventions are those practices that aim to identify a real or potential problem, motivate an individual to do something about it, and facilitate referral on to appropriate interventions."***

CARATs do not provide interventions for prisoners whose problematic substance use is solely alcohol, unless the establishment has secured funding locally from either the Drug and Alcohol Action Team (DAAT), or from other sources. The funding will in many cases be used to enhance the CARAT team by recruiting a specialist alcohol worker or by providing alcohol specific training for existing staff.

Brief interventions

Within a prison setting, screening for and provision of brief interventions are those practices that aim to identify a real or potential problem, motivate an individual to do something about it, and facilitate referral on to appropriate interventions.

All prisoners undergo a screening process, carried out by healthcare and prison induction staff, on reception into a prison. Any individual identified as having problematic substance use is referred to CARATs for a Substance Misuse Triage Assessment (SMTA). This brief assessment should highlight any problems and/or risk associated with the individual's alcohol use and assist the CARAT worker to identify and prioritise suitable interventions to address the immediate need. During this assessment a CARAT worker would also make use of AUDIT (Alcohol Use Disorder Identification Test)[5], a validated screening tool that identifies those individuals who are not currently considered to be dependant on alcohol, yet are at significant risk of harm.

There are some prisoners who may have been referred to CARATs by healthcare or induction staff who, in their own opinion, do not have a problem with drug/ drug and alcohol use. In this situation, a CARAT worker would not carry out an SMTA but would take the opportunity to explore ambivalence and provide relevant advice and information, supported by information leaflets.

Following the SMTA, and depending on the need identified, CARATs would provide the following relevant brief interventions:

General awareness raising: this aims to increase an individual's understanding of the risks of heavy drinking and provides harm reduction and health promotion advice and information. This intervention will help to enable the individual to: make informed choices about their drinking; raise the threshold of awareness about the impact of alcohol on all aspects of their life and; help them identify ways to reduce their drinking. The need of the prisoner and the length of time in custody determine the extent of what is provided, when, and how; it may be that a single intervention is delivered on an individual basis or in a group setting, or a number of interventions are delivered over a period of time.

One-to-one brief motivational session: this aims to increase an individual's motivation to accept and engage in treatment. This intervention consists of 2-4 sessions with a maximum of one hour per session; the focus of the session will depend on what stage the individual is at within the process of change and uses motivational interviewing (MI) techniques to encourage change.

Pre-release intervention: this aims to: consolidate any previous alcohol interventions that have taken place whilst in custody; reduce the risk of harm in the initial days following release; and maximise the chances of the released prisoner making use of treatment and/or support available in the community. The content of this intervention will vary, depending on the need of the prisoner, and will take into consideration their previous treatment. This intervention may be delivered over one or two sessions.

As well as CARATs, there are other departments within prisons such as healthcare, education and chaplaincy where prisoners may be able to access information and advice, and receive brief opportunistic interventions encouraging and supporting them to address problematic alcohol use.

By providing these brief interventions, the Prison Service strives to achieve positive outcomes in reducing the risk and harm associated with problematic alcohol use, not only within its establishments, but more importantly, in the wider community beyond the prison gates.

Gail Styles, Drug Treatment Adviser in the Prison Service Intervention and Substance Misuse Group.

1 ONS (1999) Substance misuse among prisoners (99) 255 27. http://www.statistics.gov.uk/pdfdir/drugs0799.pdf

2 Department of Health (2004) The National Alcohol Harm Reduction Strategy.

3 HM Prison Service (2004) Addressing Alcohol Misuse A Prison Service Alcohol Strategy for Prisoners London.

4 HM Prison Service (2004) Alcohol treatment/interventions good practice guide Department of Health

5 AUDIT – screening tool developed by World Health Organisation (WHO) in 1992 for identification of hazardous and harmful drinking in a primary care setting.

Getting released from prison may sound to many like a positive event in a person's life. *John Podmore* argues that it is often a time for risky substance misuse patterns, increased mental health problems and a return to offending. He suggests that services should do all they can to support pathways between prisons and the community. Ed.

Getting out of Jail

"Freedom is what you do to what's been done to you"

Jean-Paul Sartre.

Fewer than 40 individuals held in English and Welsh prisons are serving whole-life tariffs. There are others on indeterminate sentences who will inevitably pose too high-a-risk for the Parole Board to grant release to, and will remain in prison for a significant period of time. The vast majority, however, will return to the community after either days or decades in prison. Whilst the general public are primarily concerned with the necessity – or otherwise – for prison, the problems and the inherent dangers of release tend to get much less consideration. Deterrence, retribution and rehabilitation are frequently discussed; survival back in a community, especially for a problematic substance misuser is much less considered.

> ***"Two-thirds of those coming into prison will lose their jobs. Some 30% of those leaving prison will be homeless….This can only get worse in the current economic climate"***

'Socially excluded' describes the bulk of the prison population and the mere act of imprisonment, even for a short period of time, can add to this exclusion. Two-thirds of those coming into prison will lose their jobs. Some 30% of those leaving prison will be homeless. In London, that equates to 7,500 individuals from across the country released into the capital with nowhere to live. This can only get worse in the current economic climate.

Post-release dangers

For those not involved in the criminal justice system, there is considerable misunderstanding about the process of release from prison. Whilst the norm is for release to occur at a prescribed time in a sentence, often with licence conditions, for many release can be as chaotic as the lifestyles that got them into custody in the first place. Many are released from court. Only half of all remand prisoners go on to receive a prison sentence and, therefore, are released - unplanned - into the community. This lack of structure is often compounded by the common problems for those involved in the criminal justice system of drugs, alcohol and mental health: the consequences for some can be dire.

Even those who are aware of a release date may not receive support at release. Those on short sentences (less than 12 months) will be released without statutory supervision. In addition, fewer offenders are receiving flexible early release via Home Detention Curfew (electronic tagging), parole, and release on temporary licence, all of which may offer support with housing and employment.

The consequences of lack of support at release for the health of offenders can be as grave as are the consequences on their re-offending. In the first week of release men are 29 times more likely to die than their peers and women 69 times more likely[1]. One in three of the deaths involve a single drug, and 87% involve opiates. Those with a history of injecting drug use immediately prior to release, those with longstanding opioid dependence and those who are poly-drug dependent comprise the highest risk groups. In addition, recently released prisoners are at greater risk of suicide than the general population – at a rate equivalent to that of discharged psychiatric patients. The two most at-risk groups are substance users with poor treatment regimes and, not surprisingly, those with mental illness.

Action to reduce risk

The National Offender Management Service (NOMS) has identified 7 key components (pathways) for resettlement: accommodation; skills and employment; health; drugs and alcohol; finance, benefit and debt; children and families; and attitudes towards thinking and behaviour. Some practitioners have added *victims* as an additional category and recent work by the Prison Reform Trust has highlighted additional work that needs to be done with regard to older prisoners and those with a learning disability. The task for dealing with difficult and damaged people leading chaotic, disordered and socially excluded lifestyles remains immense.

Significant attention is now being given to drug misuse through the IDTS in prisons. This has seen a greater focus on stabilisation and maintenance integrating with psycho-social programmes and throughcare to other prisons and the community. Mental healthcare has improved with the transfer of responsibilities for health in prisons to PCTs, and Lord Bradley's review on how offenders with severe mental health problems can be diverted away from prison and into more appropriate accommodation is awaited with much anticipation.

Nevertheless, any practitioner working within or alongside the criminal justice system will see the huge gaps that need to be filled and NOMS is designed as the mechanism to fill these gaps. Of the seven resettlement pathways, some receive core Government funding, and others benefit from the annual sum of £37 million provided by third sector organisations. However, equal attention to all the pathways based upon need, and good integration between the pathways remain unachieved goals. Service providers across the health and the criminal justice systems continue to wrestle with the friction between outputs and outcomes. In the meantime, for offenders, patients, and clients, whilst leaving prison is not quite a risk behaviour, it is undoubtedly a risk factor.

John Podmore Chair of Release, former Governor HMP Brixton

1 Farrell M and Marsden J (2005), Drug-related mortality among newly released offenders 1998 to 2000 Home Office Online Report 40/05.

The introduction of the prison Integrated Drug Treatment System in England

…*continued from page 3*

The study found evidence that substitution treatment could reduce rates of re-offending and, at four-year follow-up,[5] the rate of mortality among released prisoners.

Conclusion of the review and subsequent actions

The review resulted in a fundamental re-conceptualising of clinical policy. A new set of clinical guidelines for the management of drug dependence was issued in 2006 [6] that sought to reduce suicide risk though active and immediate (i.e. first night) management of substance withdrawal. This guidance also included the recommendation of opioid prescribing (methadone or buprenorphine) to stabilise opioid dependence, after which the patient would be given a choice of maintenance or detoxification at a rate at which they felt comfortable. Opioid maintenance would offer the potential benefits of protection against fatal overdoes on release, and a reduction in the rates of re-offending (and, therefore, re-imprisonment).

> ***"The prison population has been growing significantly in recent years, and IDTS is being introduced within a context of a crowded and stretched custodial environment"***

To provide further protection against suicide in the first 28 days of prison custody, [1] and to ensure alignment with the published evidence for the effectiveness of substitution treatment, [7] the review also concluded that enhanced psychosocial interventions should be available to all problematic drug users entering prison for the first 28 days of their custody. This second aim could only feasibly be achieved through the integration of prison clinical and psychosocial services, with the psychosocial services providing the vital case management (i.e. key-worker) function.

Seventeen of the 49 first-wave prisons were also provided with resources to introduce the enhanced psychosocial interventions for the first 28 days of custody. The range of these interventions was set out in a new guidance document to commissioners and providers of CARAT services, *Integrated drug treatment system: The first 28 days: psychosocial support* [8]. Allocations for CARAT services in the 17 selected prisons included a premium to fund additional officer time to escort clients to and from treatment interventions, and to provide security at medication queues.

Risks and challenges

Commitment: In a penal system where even a legal drug is banned (alcohol), it is difficult for prison managers, and even practitioners, to understand why it is important that a substitute (for example, methadone) for an illicit drug (heroin) should be available to prisoners. Making the whole system aware of the advantages of substitution treatment, in terms of reduced risk of death and reduced rates of re-offending, [4, 5, 9, 10, 11] has been an ongoing element of the introduction of IDTS.

Commissioning: The complexity of bringing together three partners to ensure integration at the planning and financing level of IDTS has brought its own challenges, as has an internal re-organisation in the National Health Service. As they enter their third year in post, the growing experience of IDTS Regional Development Managers has enabled them to promote more timely and thorough commissioning as the programme increases in size. The latest expansion of IDTS has seen commissioners from the new sites utilising the experience of commissioners from the earlier IDTS sites in planning and procuring services.

Staff recruitment and retention: Recruitment and retention of prison drug treatment staff has been a long-standing challenge in some areas of the country. This usually applies to clinical staff, but also to prison officers and CARAT staff in some locations. The national project team compiled and issued guidance to IDTS partners on staff recruitment, alongside materials for a national advertising campaign.

The physical environment: The prison population has been growing significantly in recent years, and IDTS is being introduced within a context of a crowded and stretched custodial environment[12]. Many of the prisons in England were built in the 19th century, so space to provide individual and group treatment rooms and to accommodate new staff has been difficult to secure. Imaginative use of existing facilities and re-investment of any spare expenditure revenue has helped to mitigate this problem. To engender true integration, local IDTS planners have been encouraged to create a shared location for CARAT and healthcare services to form IDTS teams.

With IDTS services growing and coming into full effect, a large multi-site study is set to begin this autumn, with a full range of in-prison and post-release outcomes measured, incorporating rates suicide and self-harm, overdose and offending behaviour.

Dave Marteau, Clinical Substance Misuse Lead, Offender Health.

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12 Lord Carter of Coles (2007) Securing the future: Proposals for the efficient and sustainable use of custody in England and Wales, House of Lords, London.

Firoza Saloo **outlines the key aims and components of the psychosocial element of IDTS. She also highlights the positive benefits of the psychosocial interventions from both the service users and the practitioners' points of view. Ed.**

Implementing the psychosocial element of the Integrated Drug Treatment System in prisons: an 'on the ground' perspective

Currently, 91 prison-PCT partnerships have received funding for an enhanced clinical IDTS service; 29 of these partnerships have also received funding for an enhanced CARATs service to permit the development of a full IDTS service.

What is the psychosocial element of IDTS?

The First 28 Days: Psychosocial Support [1]document was distributed to prison CARAT teams in March 2006 and provided a detailed description of how to deliver the psychosocial element of IDTS in the first-wave prisons. This document worked alongside *Clinical management of drug dependence in the adult prison setting* [2] by providing guidelines on how existing psychosocial services within prisons would be reconfigured under IDTS to allow delivery of the key elements of IDTS.

The framework worked on the premise that pharmacological treatment (detoxification and maintenance programmes) and psychosocial treatment are considerably more effective when they are delivered in an *integrated and harmonised manner.* The initial 28-day period of custody was recognised as a critical period of time for problematic drug users (PDUs) who are vulnerable to suicide [3 4]. The engagement of the client at this point can provide support and be crucial to their continuous treatment journey.

What is the aim of the psychosocial element of IDTS?

The main aim of the psychosocial element of IDTS is to provide a 28-day structured care package of psychosocial support for prisoners with problematic drug use which complements clinical interventions, takes into account previous treatment in the community or custody, and provides a platform for longer-term drug treatment in prison and on release. A three-phased prisoner's treatment journey based on the National Treatment Agency's (NTA) Models of Care Update [5] provides a flexible framework and is used to illustrate the different component stages through which most prisoners undergoing treatment will pass, and the enhanced services that will be available to them under IDTS.

IDTS Psychosocial support interventions resource pack.

The framework for psychosocial interventions is supported by the IDTS psychosocial support brief interventions resource pack. This consists of ten 90-minute standardised brief intervention sessions on a wide range of topics including; relaxation, harm reduction, motivation to change, healthy living and diet, and relapse prevention.

The resource pack outlines taster sessions for those undergoing drug treatment for the first 28 days. These aim to encourage motivation and engagement, and thereby provide a platform for longer-term drug treatment in prison and on release. They also provide essential harm reduction advice, particularly for those who are in prison for a short period of time and therefore unable to access longer-term treatment interventions.

An 'on the ground' perspective

IDTS is starting to bring considerable and noticeable improvements to the quality of prison treatment. Rolling out the psychosocial element of IDTS has resulted in greater integration of working between healthcare and CARATs, with staff now expected to jointly assess and review prisoners' progress as well as co-facilitate the delivery of the psychosocial interventions. Whilst the introduction of IDTS has proven to be a challenging task - for example negative attitudes have to be addressed, and communication between disciplines must be worked upon - the majority of leads see the increase in joint working as a positive step forward for both clients and staff.

The IDTS psychosocial interventions have been very well received at establishments by workers, managers and prisoners who all recognise the benefits of structured brief interventions. The following comments provide some views from workers and prisoners on the sessions:

"the structured brief interventions ensure critical information is being given to prisoners ...participants are becoming more aware of how to reduce risks of overdose and confident in knowing what to do when others overdose in front of them. The session where they learn to put someone into the recovery position is extremely popular."

1 National Offender Management Service (2006) Integrated Drug Treatment System: The first 28 days: psychosocial support, Drug Strategy Unit, London

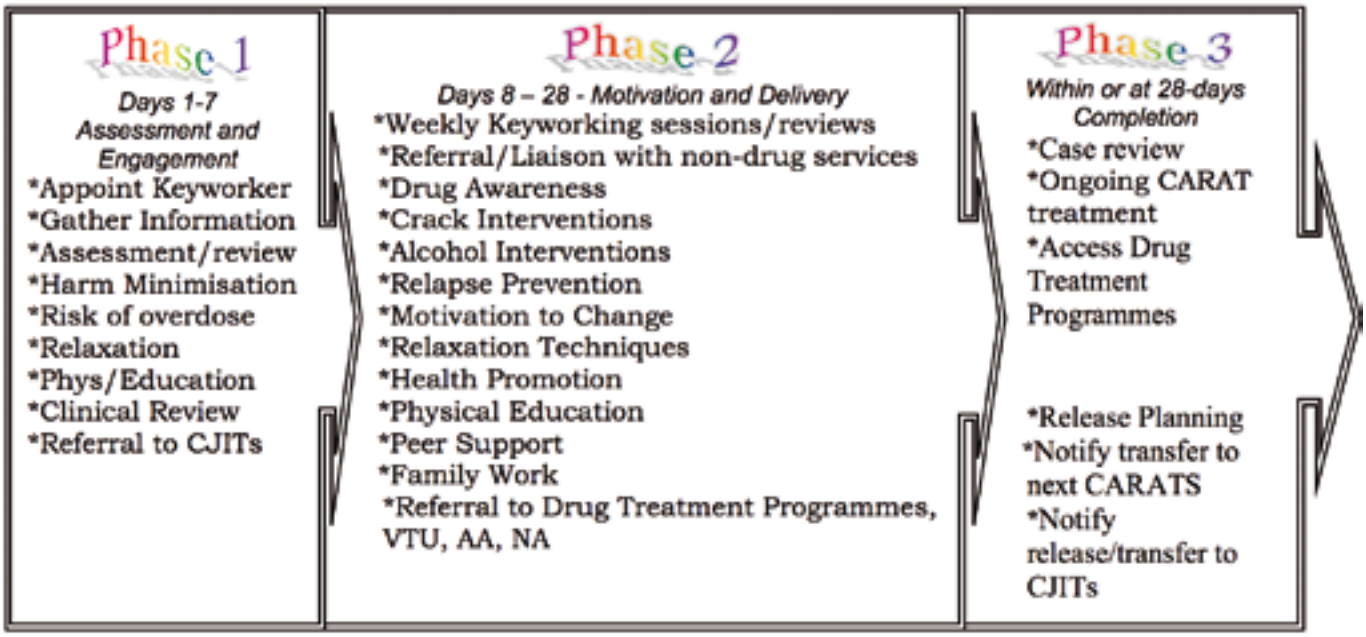
2 Department of Health (2006) Clinical management of drug dependence in the adult prison setting, 277393, London

3 Shaw J, Appleby L and Baker D (2003) Safer Prisons: A National Study of Prison Suicides 1999–2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness London: Department of Health

4 HMP Safer Custody Internal Report (2002).

5 Department of Health (2006) Models of care for treatment of adult drug misusers: Update National Treatment Agency

The client's phased, psychosocial support, treatment journey during the first 28 days



"I learnt how to control my breathing when relaxing…and I have learnt lots of ways to help me relax."

"learnt about not sharing....learnt a lot about hepatitis C...got the proper facts about drugs."

"Learnt about help inside and outside prisons…learnt to use treatment to the full."

"Looking at the situations drugs put people in gives me lots of motivation."

"Looking at how to break the chain is really helpful."

"Learnt how to control feelings, how to live without drugs, how to stay healthy and change lifestyle."

"Learnt how change is possible… made me understand where I am in the cycle of change.. it made me realise where I did not want to be."

Future developments

Following extensive consultation, both the psychosocial resource pack and the guidance[1] are in the process of being revised with updated versions being made available later this year. These will incorporate changes recommended by both practitioners and service users.

Overall the process of implementing IDTS has been a huge challenge for prisons. However both frontline workers and managers value and welcome the improvements and benefits IDTS brings to enhancing existing services by allowing the provision of a more rounded and comprehensive service for their clients. With plans to roll-out IDTS more widely across the prisons, drug treatment in prisons will be in a significantly better position to meet the needs of prisoners and the challenges of the future.

Firoza Saloo, Senior Treatment Policy Manager, Interventions & Substance Misuse Group, National Offender Management Service.

Call for papers, film and other media

A date for your diary! The 14th National Conference: Working with Drug and Alcohol Users in Primary Care will take place at ACC Liverpool on Thursday 7th and Friday 8th May 2009.

Many of you have been to the previous events and those that haven't are missing a treat so book your place now! Here is the call for papers, film and other media. Why not use this as an opportunity to share ideas, such as audits that have worked (or not worked) for you and / or your service, with other colleagues working in the same field? They don't have to be rigid research papers (unless you want to) but it is vital that we share ideas in this rapidly developing, expanding and important area of our work. We look forward to receiving your abstracts by February 20th 2009! Submissions must be received by 20 February 2009.

For more information contact Matt Davenport
Tel: 020 8541 1399 E-mail: matt@healthcare-events.co.uk

Dr Fixit on pathways between the community and prisons

Mark Williamson **answers a question from a GP about care pathways between the prison and the community. Ed.**

Dear Dr Fixit

John is a long-term patient of mine who is due to be released from prison, hopefully in a few weeks. He was very stable on 100mg of methadone mixture before his arrest (for a driving offence, nothing to do with drugs) but was detoxed in prison, without discussion with me, even though they knew I was the prescriber. John has written to me. He sounds angry about his treatment in prison, and I am really concerned about his risk of death on discharge. I have asked him to present to the surgery first, even before seeing his mum and certainly before using drugs, and I hope he will.

But is there anything else I can do? I am aware that the policy has changed and people can now continue their methadone prescriptions while in custody. And are there any policies I can use to challenge the prison? Did I hear that some prisons are now going to issue FP10s for 2 weeks to avoid this problem?

Answer provided by
Dr. Mark Williamson, *Senior medical adviser SCLGCP DH Primary care clinical lead for NpfIT, NHS Yorkshire and the Humber, GP, The Quays and HMP Hull.*

Firstly I would like to congratulate you on the quality of your doctor-patient relationship with John and your determination to support him as best you can through this difficult period for him. Supporting patients and giving them continuity of care as they pass through the criminal justice system must be the focus now the NHS is responsible for the commissioning of primary care in prisons to an equivalent standard as is found in the community. You are a key person to help provide this continuity in substance misuse care, primary care and any other care pathway that he may require, in conjunction with John himself and the prison primary care team. It is effective communication between clinical professionals which, as in the community, is the bedrock of continuity and quality of patient care. This has been relatively poor in the past because the prison system has been an isolated health system. It is now firmly in the NHS family.

He is understandably angry if he feels he has been coerced in to accepting a methadone reduction programme and detoxification in the prison against his preference. This should now occur in the prison no more as it does in the community. IDTS, the Department of Health (DH) and the NTA [1] aim to increase the volume and quality of treatment available to prisoners. IDTS places a particular emphasis on treatment at the early stage of custody, and this should start to address better integration between clinical and CARAT services. Obviously, I cannot comment on the appropriateness of his care programme to date, not knowing the case in detail. The IDTS guidelines you are alluding to in your question should be seen as robust guidance with the key watchword being "equivalence". If your local services provide a particular aspect of substance misuse therapy then it should increasingly become available in the local prison.

He is also right to be concerned, as you clearly are, about being opiate naïve, due for release and without continuing psychosocial care and support. Evidence from the Home Office Online Report Series 2003 (HOORS) shows that drug users are 40 x more at risk of death in the first week after release from prison than the general population, the predominant cause being accidental overdose. A celebratory fix may indeed kill him.

If he is at risk of using, and he is expressing this to you and the prison clinical team, then there are a number of options available in this situation. I would not like to recommend one over the other, as I cannot know the full facts of his individual case. If there is a need here for expert input, this should come from your local specialist substance misuse service, referral to which wouldn't be a bad idea given this identified level of risk. They may well identify alternative options and be able to support your patient intensively. Their support in changing the approach of your local prison would also be helpful.

Firstly, he could take the risk, see you, and be treated on release in the best way you see fit at the time. If you assess him as requiring re-induction with substitute medication he should begin treatment as described in the national guidelines and the BNF, starting low and building up slowly to a level which suppresses the risk of use. He may yet develop a determination to "stay clean" following his detox. So the decision to take this course must be on the balance of risk: preventing overdose versus contributing to a new phase of opiate addiction.

Secondly, he could be protected from the effects of drug use by a naltrexone prescription, in conjunction with psychosocial support, from the drug teams both in the prison and in the community. This treatment will need to be started prior to release and protocols on liver function testing should be enacted (BNF).

Thirdly, he could undergo a prison re-induction using buprenorphine or methadone, prior to release. This is a viable option, and a pragmatic approach to safety. It is not a feature of the IDTS document or the subsequent continuity guidance [2], but it is recommended in the 2007 Clinical Guidelines [3]. The need to increase methadone treatment levels is mentioned in the IDTS guidance if it is felt that the prison dose is insufficient to prevent use on discharge.

Fourthly, following re-induction in the prison he could be issued with a short prescription on an FP10 for an opiate substitute to support him on discharge and to reduce his cravings. However, the use of FP10s is currently only on a pilot basis in a few prisons nationally.

Clearly there are risks that he may use on top with the third and the fourth options, so there is a need for careful clinical planning and supervision with the patient, his prison CARAT and IDTS team and the drug team to whom he will be released, as well as yourself. Continuity of his prescription will be essential and should be on the condition of certainty of information from the prison prescribers, clinical assessment, and regular urine testing.

The aim nationally - and this is the reason for the IDTS approach - is that as many opiate drug users as possible on short sentences (6-12 months) are maintained on methadone throughout their prison sentence, supported by the CARAT workers and IDTS teams, so that on release their lives can be stabilised and their safety maintained.

Good luck with this case, and your discussions with the prison. Somehow I think things will work out for John.

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3. DH (2007) Drug misuse and dependence. UK guidelines on clinical management

Dr Fixit and dual diagnosis

Dear Dr Fixit

I am based in a prison and I have a patient who has received a diagnosis of heroin dependence, anti-social personality disorder and depression. It seems that mental health services do not want to acknowledge his drug problem and drug services do not like the idea of one of their patients being called "personality disordered". The patient is also refusing to take anti-depressants and says he has fallen out with the Mental Health In-Reach Team. How do I proceed?

Answer provided by Nat Wright,
Clinical Director for Substance Misuse, HMP Leeds.

Such patients commonly present to the prison-based clinician. Often they have been discharged from other services for failure to engage in treatment, defaulting from treatment or making threats of violence towards staff members. Those with dual diagnosis, or co-morbidity, have significantly worse outcomes in terms of: worsening psychiatric symptoms; increased use of services; increased risk of becoming homeless; poor compliance with medication; increased risk of blood-borne viral infection; increased risk of imprisonment; increased risk of violence and suicidal behaviour; and increased occurrence of suicides[1].

A patient is likely to have received a diagnosis of anti-social personality disorder based upon the patient displaying all or some of the following attitudes and behaviours: failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest; deceitfulness, as indicated by repeatedly lying, use of aliases, or conning others for personal profit or pleasure; impulsivity or failure to plan ahead; irritability and aggressiveness, as indicated by repeated physical fights or assaults; reckless disregard for safety of self or others; consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations; and lack of remorse, as indicated by being indifferent to or rationalising having hurt, mistreated, or stolen from another[2]. Be aware that the term *personality disorder* can be value laden and, therefore, contentious and I would suggest that you do not let disagreements about terminology prevent you from working constructively with your patient.

A common feature with heroin dependence, personality disorder and depression is that those who benefit from a strong therapeutic alliance with a clinician have better outcomes than those to do not; so the professional who lacks empathy and is judgemental towards this group is less likely to improve their outcomes. Try to find out why the patient has not engaged with other services and assess how much their conditions are problematic in the sense that they interfere with their ability to conduct daily living activities. Those with severe illness could be at risk of suicide or self-harm and will need to be supervised through the prison *Assessment, Care in Custody and Teamwork* (ACCT) care-planning system. This can be initiated by either a discipline or healthcare professional, and makes provision for ongoing observation of the patient. Be aware that suicidal tendencies can be a manifestation of the impulsive, reckless behaviours that are a part of personality disorder (and not necessarily a part of the depressive disorder); failure to recognise this is a common error and occasionally a suicide will take place in prison very soon after the ACCT document has been closed.

As primary care clinicians in this scenario we should, wherever possible, encourage the patient to be compliant with treatment and to focus on realistic goals such as improved functioning in conducting the tasks of daily living. Find out why the patient is reluctant to remain in treatment with the Mental Health In-Reach Team. It could be that he needs to be encouraged to make and keep realistic boundaries with professionals. Alternatively, it could be that some professionals in the Mental Health In-Reach team regard personality disorder as a diagnosis of exclusion (in my experience such an attitude is also common amongst primary care staff). Such an attitude does little to foster a therapeutic milieu in which the patient can address their issues. Those with mild or moderate co-morbidity can easily be managed in primary care, and the change of treatment setting from secondary to primary care may be sufficient to engage the patient to become compliant with anti-depressant medication.

In addition, the primary care clinician can offer opiate maintenance therapy with ongoing motivational enhancement therapy if the patient is unable to remain abstinent from illicit opioids.

However, for those with severe co-morbidity (either depression or personality disorder), transfer to either a secure hospital or to a specialist unit for personality disorder may be indicated and this will need to take place in collaboration with the Mental Health In-Reach Team. Don't be frightened to act as the patient's advocate in this instance. You may need a medium-term plan to work with senior managers, governors and clinicians to address the 'silo-thinking' that still pervades some parts of some prison healthcare departments. Personality disorder can be prevalent in over 75% of prisoners[3] so prison-based drug services simply cannot ignore such behaviour traits and hope to offer effective drug treatment. Similarly the link between illicit drugs and mental ill-health has been a focus of recent policy initiatives and specialist mental health services need to offer effective treatment for those with dual diagnosis issues[1]. Such issues can be addressed through the Prison Partnership Board and the relevant health committees. Fostering supportive shared pathways for the care of such patients can prevent the sense of isolation and helplessness that can so easily be experienced in the consultations of the prison-based primary care clinician seeking to offer effective options for those with co-morbidity.

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BULLETIN BOARD

NTA Regional Harm Reduction Events

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5th National Conference on Sexual Health and Contraception in General Practice Sexual Health in the Surgery Not as hard as you think: Improving Pathways and Sharing Good Practice 27 February 2009 The Palace Hotel Manchester
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For all enquiries, please call 01305 262244 or email **info@exchangesupplies.org**

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Family Medicine: From Cradle to Grave Thursday 7 May - Friday 8 May 2008 ACC Liverpool
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RCGP 14th National Conference Working with Drug & Alcohol Users in Primary Care - Family Medicine: From Cradle to Grave Thursday 7 May - Friday 8 May 2008 ACC Liverpool Call for Posters, Papers, Film & Other Media You are invited to submit posters, papers, film and other media on any aspect of the management of drug and alcohol users in Primary Care.
Submissions must be received by 20 February 2009.
For more information contact Matt Davenport Tel: 020 8541 1399 E-mail: **matt@healthcare-events.co.uk**

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National Treatment Agency for Substance Misuse

RCGP Certificate in Substance Misuse: additions for those working in Secure Environments and how to apply

The RCGP Certificate in Substance Misuse has been modified to take into account the learning needs of clinicians practising in prisons and other secure environments. The Part 1 face-to-face day remains a one day course with much of the content of the generic Part 1 course. In some parts the content has been modified to reflect issues particular to practice in the secure environment. Following successful completion of the Part 1, lead IDTS practitioners are encouraged to complete the Secure Environments module. This is a two day face-to-face course, **arranged via IDTS Regional Development Managers**, that covers in more depth the best practice management of drug users presenting in the Secure Environment. Currently the course is run every three months at differing locations around the country. Following successful completion of the Secure Environments module some participants wish to undertake the generic Part 2. This five day course (which also requires substantial study outside of this time) is recommended for those who have substance misuse clinical lead responsibility, or those seeking to develop competencies of a practitioner with special interest in the management of substance misuse.

For more information, or to reserve a place please contact Jo Betterton

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